Zygmont Chiropractic Center

Please **print clearly** and complete all information to its entirety

Contact Information

Patient Name:________________________________

Address:________________________________

City/State/Zip:________________________________

Home Phone:________________ Work Phone:________________

Cell Phone:________________ E-Mail:________________

Personal Information

Name Preffered to be called:________________________________

Date of Birth:____________ Gender:____________ Age:____________

Status: Single Married Seperated Divorced Widowed

Spouse/ Guardian Full Name:________________________________

Relationship:________________________________

How did you hear about us?________________________________

Patient Employment Information

Employer:________________________________

Address:________________________________

City/ State/ Zip:________________________________

Phone:________________________________

Occupation:________________ How Long:________________

Emergency Contact Information

Name:________________ Relationship:________________

Home Phone:________________ Work Phone:________________

Personal Health Information

How often do you exercise? never 1/wk 2/wk 3/wk daily

What is your preferred form of exercise? ______________________

Have you significantly changed your exercise program in the last 90 days? Y / N

If so, what has changed (frequency, volume, intensity)? ______________________

Do you have an upcoming exercise event/competition? Y / N If so, when? ____________

How often do you use tobacco? never daily weekly monthly yearly

How many servings of alcohol do you drink weekly? 0 1-2 3-5 5-7 7+

Please mark the following as they pertain to you:

- ❑ HIV Positive
- ❑ Hepatitis
- ❑ Bleeding Disorder

- ❑ Cancer ____________
- ❑ Malignancy
- ❑ Spinal Bone Tumors
- ❑ Vertebral Column Infections
- ❑ Prostate Problems
- ❑ Unexplained Bruising
- ❑ Fatigue
- ❑ Unexplained Weight Gain/Loss
- ❑ Loss of Appetite

- ❑ High Blood Pressure
- ❑ Heart Attack
- ❑ Stroke
- ❑ Arterial Aneurysm
- ❑ Chest Pain
- ❑ Irregular Heart Beat
- ❑ Angina
- ❑ Vascular Disease
- ❑ Neurological Deficit
- ❑ Vertibrobasilar Insufficiency
- ❑ Abdominal Pain
- ❑ Abdominal Surgery
- ❑ Liver/Gall Bladder Condition
- ❑ Lupus
- ❑ Autoimmune Disease
- ❑ Joint Disease
- ❑ Kidney Condition
- ❑ Bladder Infection
- ❑ Visual Disturbance
- ❑ Asthma/Shortness of Breath
- ❑ Bone Demineralization
- ❑ Loss of Sensation
- ❑ Painful Urination
- ❑ Ulcer
- ❑ Allergies
- ❑ Fainting
- ❑ Dizziness

- ❑ Diabetes
- ❑ Diarrhea
- ❑ Change in Urination
- ❑ Nausea
- ❑ Unusual Thirst

- ❑ Headaches
- ❑ C Spine/Neck Pain
- ❑ Upper back Pain
- ❑ Mid back Pain
- ❑ Low back Pain
- ❑ Shoulder Pain
- ❑ Elbow Pain
- ❑ Wrist/Hand Pain
- ❑ Hip Pain
- ❑ Thigh/Leg Pain
- ❑ Knee Pain
- ❑ Ankle/Foot Pain
- ❑ Jaw Pain
- ❑ Unstable Fracture

- ❑ Loss of Bladder Control
- ❑ Cauda Equine Syndrome

List all prescription medications you currently take:

Name of Prescription	Purpose of Prescription

What is the reason for your visit?

1.) What would you like the **main priority** of this visit to be?____________________________

____

When did your pain/complaint begin?____

Did your pain/complaint start with an event / training / injury? Y / N

If so, please explain: ____

____

Do you experience your pain/complaint at rest? Y / N

Does your pain/complaint affect your daily activities or routines? Y / N

Has your pain/complaint affected the quality of your sleep or ability to sleep? Y / N

Is your pain/complaint worse at certain times of the day? Y / N

If so, when?:____

____

What does your pain/complaint feel like? Dull/Achy Sharp Numb Tingling Burning Cold Heavy Tight

Explain:____

What makes your pain/complaint worse (sleeping, sitting, standing, running, lifting etc.)?_______

____

If anything, what are you doing to manage/improve your pain/complaint?

- ❑ Stretching
- ❑ Ice
- ❑ Heat
- ❑ Foam Rolling
- ❑ Medication
- ❑ Supplements
- ❑ Therapy
- ❑ Massage
- ❑ Other______________________

How often do you experience your pain/complaint? ____________________________________

____

How is your pain/complaint changing with time? ______________________________________

____

How much has the primary pain/complaint interfered with your work? ________________________

____

Have you seen another provider for this pain/complaint? Y / N

If so, who and when? ____

Have you had any previous imaging done? Y / N

If so, where and when? ____

List all over-the-counter medications you currently take:

Name of OTC Medication	Purpose of OTC Medication
______________________	______________________
______________________	______________________
______________________	______________________

List all supplements you currently take:

Name of Supplement	Purpose of Supplement
______________________	______________________
______________________	______________________
______________________	______________________

List all surgical procedures you have had: ______________________

____

List all times you have been hospitalized: ______________________

____

List all significant past traumas: ______________________

____

Women Only

Are you pregnant or trying to become pregnant? Y / N

If so, how many weeks pregnant? ______________________

Are you nursing? Y / N

Are you taking birth control? Y / N

Do you have breast implants? Y / N

Is there anything else you think we should know? ______________________

____

____

Do you have a trainer/coach/physician you would like us to share your treatment plan with? Y / N

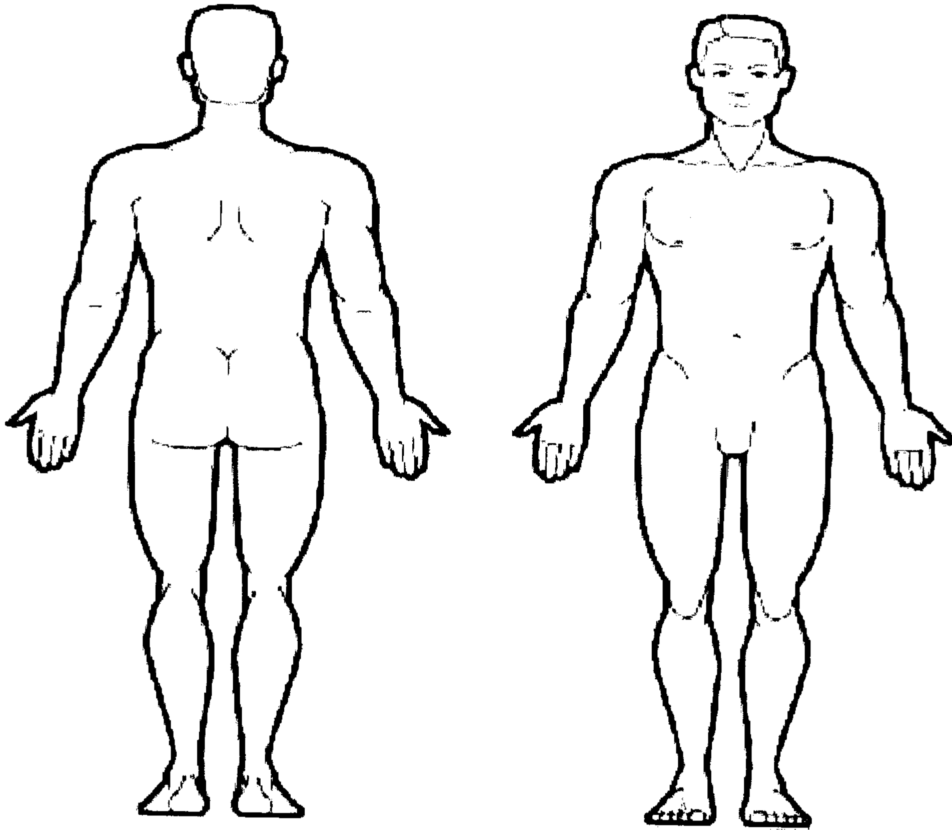
Name: ______________________

Contact Information: Phone number: ______________________

E-mail address: ______________________

Place of business: ______________________

Please circle areas of pain/complaint with a "1" if it is the primary concern, or a "2" if it is the secondary concern for your visit.



On a scale of 0-10 (0 being no pain and 10 causing thoughts of suicide) rate your pain.

1.) Primary Concern at its:

Best:____________________

Average:________________

Worst:__________________

2.)Secondary Concern at its:

Best:____________________

Average:________________

Worst:__________________

Patient or Guardian Signature: ______________________________ **Date:** __________

____
Patient name (printed)

____
Relationship to patient (if other than patient)

Dry Needling Consent for Treatment

Please answer the following questions:

Are you positive for HIV/AIDS Yes / No **Do you have a bleeding disorder** Yes / No

Are you taking blood thinners Yes / No **Have you had a previous spinal surgery** Yes / No

Are you immunocompromised Yes / No **Have you had a breast augmentation?** Yes / No

Procedure: Dry Needling involves inserting a tiny monofilament needle in a muscle or muscles in order to release shortened bands of muscles and decrease trigger point activity. This can help resolve pain and muscle tension, and will promote healing. This is not traditional Chinese Acupunture, but is instead a medical treatment that relies on a medical diagnosis to be effective. Like any treatment, there are possible complications. While complications are rare in occurrence, they are real and must be considered prior to giving consent for treatment.

Risks: The most serious risk with Dry Needling is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe puncture can require hospitalization and re-inflation of the lung. This is a rare complication, and in skilled hands it should not be a major concern. Other risks include injury to a blood vessel causing a bruise, infection, and/or nerve injury. Bruising is a common occurrence and should not be a concern.

Patient's Consent: I understand that no guarantee or assurance has been made as to the results of this procedure and that it may not cure my condition. Multiple treatment sessions may be required/ needed, thus this consent will cover this treatment as well as consecutive treatments by this facility. I have read and fully understand this consent form. With my signature, I hereby consent to the performance of this procedure. I also consent to any measures necessary to correct complications which may result.

I,____________________________________, authorize Dr. Colette Zygmont,D.C. to perform Dry Needling during my care.

You have the right to withdraw consent for this procedure at any time before it is performed.

________________________	________________________
Patient or Guardian Signature	**Date**
________________________	________________________
Patient Name(printed)	Relationship to patient(if other than patient)

Informed Consent for Treatment

Your Chiropractor specializes in the care of soft tissue injuries utilizing Active Release Techniques (ART) and Sound Assisted Soft Tissue Mobilization (SASTM). The first thing she will do is determine if your problem is muscular by nature. Should you need to see another professional your doctor will notify you as soon as possible. Some conditions may require 2 to 3 weeks to determine if ART or SASTM will be effective for your condition depending on how chronic your condition is.

Your sessions may be uncomfortable. Every individual's tissue tolerance is different. It is your responsibility to communicate with the doctor during and after care to give her feedback so that she can make modifications if necessary. In the event that your skin bruises after a session, communicate this to the provider so that she knows to apply less force in future treatments. She will also inform you if icing the area will help.

It is your responsibility to participate in your care by doing the stretches and exercises that you will be taught. It is also your responsibility to tell your provider whether or not you feel like the care is helping you.

I hereby authorize and release the doctor and any individual he/ she may designate as her assistant to administer treatment, physical examination, x-ray studies, chiropractic care or any clinical services that she deems necessary in my case. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as "rare" and the probability of adverse reaction due to ancillary procedures is also considered "rare".

I hereby acknowledge that if I do not keep appointments as recommended to me by my treating doctor, she has complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. I understand that failure to complete my recommended treatment plan may jeopardize my care.

Patient or Guardian Signature:____________________ Date:____________________

______________________________ ______________________________

Relationship to patient(if other than patient) **Patient name (printed)**

Late Cancellation/ Reschedule and Missed Appointment Policy

Because we schedule a limited number of appointments each week, we need to be able to depend on these appointments to successfully operate our practice. Therefore, we have established the following office policy for missed appointments in order to improve our care for you and our other patients.

A **24 hour notice must be given for all cancelled/rescheduled appointments** so that others may be scheduled in your place. If you are unable to reach us please leave a message or e-mail to notify us of your cancellation/ rescheduling. **Arriving more than 10 minutes late without informing us, or not showing up for/ missing an appointment will be considered a missed appointment.** If you are running late and we have an opening, we will do our best to see you.

THE FEE FOR A LATE CANCELLATION/ RESCHEDULING OF AN APPOINTMENT, OR MISSED APPOINTMENT IS $50, AND WILL BE CHARGED TO YOUR AUTHORIZED CARD ON FILE FOR PAYMENT. This charge cannot be filed with your insurance provider.

I hereby acknowledge that I have received and reviewed the above policy and asked any questions I have prior to signing.

Patient or Guardian Signature:____________________ Date:____________________

______________________________ ______________________________

Relationship to patient(if other than patient) **Patient name (printed)**